STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for the State Residential Licensure Survey. Survey dates: May 28 and May 29, 2013 Facility number : 003282 Provider number : N/A AIM number : N/A Survey team: Michelle Hosteter RN, TC Gloria Bond, RN Census bed type: Residential : 84 Total : 84 Census payor type: Medicaid : 11 Other : 73 Total : 84 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on June 3, 2013.	R000000	DISCLAIMER: Preparation and implementation of this plan of correction does not consitute admission or agreement by Rittenhouse Senior Living of Indianapolis of the truth of the facts, findings, or other statements as alleged by the preparer of the Survey/inspection dated May 30, 2013. Rittenhouse Senior Living of Indianapolis specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify the physician immediately of a change in diet orders after return from the hospital for 1 of 5 residents reviewed for changes in status in a sample 7. (Resident #49) Findings include: The clinical record for Resident # 49 was reviewed on 5/29/13 at 11 a.m. Diagnoses included, but were not limited to, Type II Diabetes, Alzheimer's, depression, and abnormal gait. The notes from the hospital on a form titled, "Medical Imaging Questionnaire" indicated on 1/18/13, Resident #49 had been admitted for dehydration and hyperglycemia. Signs and symptoms were indicated as difficulty swallowing. The	R000036	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:All Licensed Nurses shall receive in-service education regarding the facility "Notification Policy - Physicians, Residents and Responsible Parties". 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The Licensed Nurses shall receive in-service education to include the facility policy "Notification Policy - Physicians, Residents, and Responsible Parties". This training shall also include proper documentation in the clinical record of these notifications. Licensed Nurses who do not	07/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physician's progress notes dated 1/18/13 from hospital indicated, "... Speech Pathology recommended thin liquid via cup only. No straws, Dysphagia chopped diet...." The discharge form dated 1/21/13 from the hospital indicated, "...Dysphagia chopped 2000 calorie diet, no concentrated sweets thin liquid with cup 1:1 supervision...encourage po intake...." The physician's orders dated 1/21/13 indicated, "...Res [resident] to have mech soft diet, thin liq [liqiud], but no straws...." the physician's signature was dated 3/18/13. There were no nurse's notes, physician's progress notes, or other physician's orders indicating clarification or changes in diet status. In an interview with the Residential Care Director on 5/29/13 at 4:10 p.m., she indicated she did not know if the physician was notified for clarification of the diet or when the diet was changed for Resident #49 after readmission to the facility after hospital stay on 1/21/13.		follow the "Notification Policy" correctly shall receive disciplinary action in the form of a written reprimand and potential for termination from their position should there be re-occurence.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:A system for new orders received has been put into place. All new orders are reviewed by either the Resident Care Director or Director of Memory Care to ensure proper transcription and follow through.5) By what date the systemic changes will be completed:Date of completion: 7/15/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to secure potentially hazardous items in their dementia unit's activity area. This had the potential to affect all 34 residents residing in the memory care area. In addition the facility failed to maintain a safe environment for 1 of 5 residents observed that did not reside in the dementia unit. (Resident #55) Findings include: 1. During the environmental tour with the Maintenance Director on the Dementia care unit, on 5/29/2013 at 1:10 p.m., a plastic container was	R000148	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The container containing the nail polish, clippers, hair pins and moisturizing lotion, as well as the metal fork found in a drawer, were removed and relocated to a safe and secured storage area during the survey. The extension cord observed was immediately removed from the resident's room.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected.3) What measures will	07/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed in an unsecured easily accessible cupboard. The container contained nail clippers, nail polish remover, 30 bottles of nail polish, a couple of hair pins, and a bottle of moisturizing lotion. In addition a metal fork was found in an easily accessible drawer. In an interview on 5/29/2013 at 1:12 p.m., with the Memory Care Director, she indicated potentially hazardous items are kept locked up or out of reach. 2. In an observation on 5/29/2013 at 1:30 p.m., during the environmental tour, Resident #55 had an iron's electrical cord plugged into to a light weight extension cord which was plugged into the wall. The Maintenance Supervisor in an interview on 5/29/2013 at 1:31 p.m., indicated the use of extension cords by the residents were not permitted in the facility. The "Resident Handbook" was reviewed on 5/29/2013 at 5:30 p.m., and indicated under "Safety," "... hot plates, electric blankets, and extension cords are not permitted."		be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:Routine safety rounds will be put into place in an attempt to ensure the facility remains free of hazards. Staff involved shall be trained to recognize and remove potential hazards at all times.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The Director of Memory Care, or her designee, shall complete safety rounds on the memory care unit two times per week for four weeks. Following the initial four weeks, safety rounds will be conducted one time per week ongoing. The Maintenance Director, or his designee, shall check all apartments to be sure extension cords are not being used. Following this initial review, routine checks will be performed weekly ongoing. In addition, Housekeeping staff will be trained to be observant of any extension cords that may have been added while cleaning resident apartments.5) By what date the systemic changes will be completed:Date of completion: 7/15/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000155	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview the facility failed to ensure garbage was disposed of in a safe and sanitary manor for 2 of 2 observations of the outside dumpster area. This had the potential to affect all 84 residents residing in the facility. Findings include: In an observation with the Maintenance Director on 5/28/2013 at 10:45 a.m., the outside garbage disposal area was observed with the surrounding wooden door open and pieces of a glass mirror, a small closed bag of unidentifiable waste, a small stack of hay and a white piece of furniture on the ground in front of the dumpster. One of the lids to the dumpster was observed open. In an observation during the environmental tour with the Maintenance Supervisor on 5/29/2013 at 1 p.m., the outside garbage disposal area had the surrounding outer door open, one of	R000155	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The dumpster area was cleared and the lid of the dumpster closed on 5/30/13.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The waste disposal contractor for the facility is being contacted to determine if a more "user friendly" dumpster can be obtained. If this is not an option, the facility will gather trash throughout the shifts in large covered cans located in the soiled utility room. These cans shall be emptied into the dumpster by Maintenance personnel a minimum of two times daily to ensure the dumpster lid is properly closed and no debris is left in the area surrounding the dumpster.4) How the corrective action(s) will be monitored to	06/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the dumpster's lids open and a white piece of furniture by the side of the dumpster. In an interview with the Maintenance Supervisor on 5/29/2013 at 1:02 p.m., he indicated the lid to the dumpster is left open because it is too heavy for the staff to open it and the glass mirror had been there the day before because he had been too busy to clean it up.		ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The Maintenance Director, or his designee, shall monitor the dumpster area a minimum of two times daily to ensure the dumpster lid remains closed and no trash, or other debris, is placed outside of the dumpster. Proper trash disposal shall be reviewed with all staff members.5) By what date the systemic changes will be completed:Date of completion: 6/21/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to have an updated evaluation reflecting the changes in dietary status of 1 of 7 residents reviewed for evaluations in a sample of 7. (Resident # 49) Findings include: 1. The clinical record for Resident # 49 was reviewed on 5/29/13 at 11 a.m. Diagnoses included, but were not limited to, Type II Diabetes, Alzheimer's, depression, and abnormal gait. The notes from the hospital on a form titled, "Medical Imaging Questionnaire" indicated on 1/18/13, Resident #49 had been admitted for dehydration and hyperglycemia. Signs and symptoms were indicated as difficulty swallowing. The physician's progress notes dated 1/18/13 from the hospital indicated, "... Speech Pathology recommended thin liquid via cup only. No straws,	R000214	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All Licensed Nurses shall receive in-service education to checklists for admission and re-admission to the facility, and the proper system for receipt of new orders. Checklists have been completed for Licensed Nurses to utilize to ensure physician orders, including diet orders, are properly transcribed upon admission or re-admission to the facility. A system for new orders is in place and all new orders are reviewed by either the Resident Care Director or Director of Memory Care to ensure proper transcription and follow through.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The Licensed	07/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Dysphagia chopped diet...." The discharge form dated 1/21/13 from the hospital indicated, "...Dysphagia chopped 2000 calorie diet, no concentrated sweets thin liquid with cup 1:1 supervision...encourage po [by mouth] intake...." The physician's recapitulation for February, March, and April indicated the diet as No concentrated sweets. There was no information regarding mechanical soft 2000 calorie diet or the use of a cup with 1:1 supervision and no straws. There were physician's orders dated 1/21/13 indicating, "...Res [Resident] to have mech [mechanical] soft diet, thin liq [liquid], but no straws...." There were no other nursing notes, physician's progress notes, physician's orders indicating any change in diet status found in the chart. The only note found in the chart from the dietician was dated 5/13/13 and indicated, "...new assessment...Diet noted 1/21/13 post hosp.[hospital] per ST [Speech Therapy] : Mech. [Mechanical] Soft [sign for no] straws		Nurses shall receive in-service education to checklists for admission and re-admission to the facility, and the proper system for receipt of new orders.The nursing staff shall utilize the checklist provided to assist in proper transcription and implimentation of physician orders upon admissiion or re-admission to the facility. The system for new orders is in place with the Resident Care Director or Director of Memory Care reviewing all new orders to ensure proper transcription and follow through.Licensed Nurses who do not follow the proper procedures as listed above shall receive disciplinary action in the form of a written reprimand and potential for termination from their position should there be re-occurrence.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The Resident Care Director, or her designee, shall review new admission and re-admission checklists within 72 hours to ensure ongoing compliance by the Licensed Nurses of the systems put into place. All new orders shall be reviewed by either the Resident Care Director or Director of Memory Care ongoing.5) By what date the systemic changes will be completed:Date of completion: 7/15/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Current signed orders note diet: NCS [No concentrated sweets] Please clarify diet-does he need Mech. Soft [sign for no] straws NCS? Unstable BS's [blood sugars] monitor how many sweets he consumes-encourage low carbohydrate items Evaluate use vs [versus] risk of Atelvia [medication to treat bone loss] wkly [weekly] dt [due to] side effects possible esophagitis/gastritis [swelling of espophagus] and resident with wt. [weight] loss...." In an interview with the Residential Care Director on 5/29/13 at 11:30 a.m., she indicated the current evaluation of resident should be in the chart and should show any changes related to diet status. On 5/29/13 at 4:10 p.m., she indicated she did not know when the diet was changed for Resident #49 after readmission to the facility after hospital stay on 1/21/13. She also indicated she could not find any documentation from the dietary department regarding change in diet status.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to have service plans reflecting services provided for 2 of 5 residents reviewed for service plans (Resident #11, and #49) and no signature from resident or responsible party for 2 of 5 records reviewed for signatures on	R000217	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Service Plan for all residents shall be audited to ensure the Service Plan addresses resident needs, preferences, current physician orders and specific medical requirements, such as	07/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the service plans in a sample of 7. (Resident #11 and #83) Findings include: 1. The clinical record for Resident # 49 was reviewed on 5/29/13 at 11 a.m. Diagnoses included, but were not limited to, Type II Diabetes, Alzheimers, depression, and abnormal gait. The notes from the hospital on a form titled, "Medical Imaging Questionnaire" indicated on 1/18/13, Resident #49 had been admitted for dehydration and hyperglycemia. Signs and symptoms were indicated as difficulty swallowing. The physician's progress notes dated 1/18/13 from hospital indicated, "... Speech Pathology recommended thin liquid via cup only. No straws, Dysphagia chopped diet...." The discharge form dated 1/21/13 from the hosptial indicated, "...Dysphagia chopped 2000 calorie diet, no concentrated sweets thin liquid with cup 1:1 supervision...encourage po [by mouth] intake...." The physician's recapitulation for February, March, and April indicated		allergies, are addressed.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The Service Plan for all residents shall be audited to ensure the Service Plan addresses resident needs, preferences, current physician orders and that specific medical requirements, such as allergies, are addressed.Upon routine six month reviews, staff responsible for Service Plans shall obtain signature on Service Plan of resident or responsible party. If Service Plan is not reviewed in person, staff member shall make notation on Service Plan of verbal review.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:Upon development of the initial Service Plan the following shall be referenced to ensure all of the resident needs and preferences are addressed: Admission Orders, Admission Assessment, Admitting History & Physical, recent Labs and Nurses Notes. The Service Plan document will be modified to include "prompts" to assist in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the diet as No concentrated sweets. There was no information found in the chart regarding mechanical soft 2000 calorie diet or the use of a cup with 1:1 supervision and no straws. There were physician's orders dated 1/21/13 indicating, "...Res [Resident] to have mech [mechanical] soft diet, thin liq [liquid], but no straws...." There was no other nursing notes, physician's progress notes, physician's orders indicating any change in diet status found in the chart. The only note found in the chart from the dietician was dated 5/13/13 and indicated, "...new assessment...Diet noted 1/21/13 post hosp. per ST[Speech Therapy] : Mech [Mechanical] . Soft [sign for no] straws Current signed orders not diet: NCS [No Concentrated Sweets] Please clarify diet-does he need Mech. Soft [sign for no] straws NCS? Unstable BS's [blood sugars] monitor how many sweets he consumes-encourage low carbohydrate items Evaluate use vs [versus] risk of Atelvia [medication to treat bone loss] wkly [weekly] dt [due to] side effects possible esophagitis/gastritis and resident with		ensuring all pertinent information is addressed in the Service Plan.5) By what date the systemic changes will be completed:Date of Completion: 7/15/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wt. [weight] loss...." In an interview with the Residential Care Director on 5/29/13 at 11:30 a.m. indicated the current evaluation of resident should be in the chart and should show any changes related to diet status. On 5/29/13 at 4:10 p.m. she indicated she did not know when the diet was changed for Resident #49 after readmission to the facility after hospital stay on 1/21/13. She also indicated she could not find any documentation from dietary department regarding change in diet status. 2. Resident #11's record was reviewed on 5/28/2013 at 12:30 p.m. Diagnoses included, but were not limited to, dementia, depression, and frequent falls. Resident #11's "Pre-assessment questionnaire", dated 4/3/13 indicated, allergies to shellfish and need for supervision with toileting. Resident #11's, "Admission Nursing Assessment", dated 4/4/13 indicated, allergies to shellfish, and urinary incontinence with possible need for bladder training. Resident #11's, "Six Month Care Plan			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review", dated 4/23/13, lacked mention of allergy to shellfish, and under continence it stated the resident was continent of B&B (bowel and bladder). The Care Plan was not signed by Resident #11 or his family. 3. Resident #83's record was reviewed on 5/28/13 at 11:45 a.m. Diagnoses included, but were not limited to, urinary incontinence, osteoporosis, osteoarthritis, neuromuscular disorder. Resident #83's record, "Six Month Care Plan Review", dated 3/13, lacked the resident's signature. In an interview on 5/29/2013 at 10:00 a.m., the Resident Care Director indicated the care plans were the resident service plans.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000300	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, record review, and interview, the facility failed to have over the counter medication labeled with resident information for 1 of 5 residents observed during medication pass (Resident #65) and failed to have a correct medication administration label for 1 of 5 residents observed during medication pass. (Resident #66) Findings include: 1. During the medication pass with on 5/29/13 at 8:25 a.m., with LPN #1, a bottle of I Cap vitamins was observed to have no written information regarding resident name or physician for Resident #65. In an interview with LPN #1 on 5/29/13 at 8:26 a.m., she indicated they usually have the resident's name and the physician's name written on the bottle. 2. During the medication pass on	R000300	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:All Licensed Nurses shall receive in-service education to include the "Medication Administration" policy that includes proper labeling of all medications.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The Licensed Nurses shall receive in-service education to include the facility "Medication Administration" policy. Training shall include proper labeling of all medication with emphasis placed on OTC medication and medication requiring a change of direction label.Licensed Nurses who do not follow the "Medication Administration" policy correctly shall receive disciplinary action in the form of a written reprimand	08/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/29/13 at 8:45 a.m., with LPN # 1, an observation was made of a bottle of medication having different information written than the order on the MAR (Medication Administration Record). The label on the bottle indicated, "Metoprolol Tartate 50 mg [milligrams] 2 tab po [by mouth] daily." The MAR that LPN #1 provided indicated, "Metoprolol 25 mg 1 po daily." In an interview with LPN #1 on 5/29/13 at 8:46 a.m., she indicated the resident was getting the medication this way to save money and that the order on the MAR was the correct amount and that they had not updated the label on the bottle yet. In an interview with the Residential Care Director on 5/29/13 at 9:00 a.m., she indicated the medication should have a change of direction label on the bottle. A policy titled, "8.80 Medication Administration" dated 4/30/08 was provided by the Residential Care Director on 5/29/13 at 11:45 a.m. The policy indicated, "...2.7 Medication name, strength, dosage form, dose, route of administration, frequency, administration time,		and potential for termination from their position should there be re-occurrence.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:Audits of the medication carts shall be performed by either the Resident Care Director, or her designee, two times per week for two weeks, one time per week for one week, one time every other week for one month and one time every other month ongoing.5) By what date the systemic changes will be completed:Date of Completion: 8/2/13 to accommodate audit time line.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	direction change sticker applied to medication if prescription label does not match physician order;...."			